Michigan Association of Health Plans

March 23, 2009

To: Representative Marc Corriveau, Chairman
House Health Policy Committee

From: Richard Murdock, Executive Director
Michigan Association of Health Plans

Subject: Follow Up From Last Week's Committee Meeting

As you will recall, there were several questions that I was not able to provide a full response or which I needed to access additional information. These questions and responses are listed below. If we can provide you or Committee members with additional information related to these issues or other issues discussed during my presentation(s) with the Health Policy Committee, please let me know.

Questions Raised During March 17th House Health Policy Committee

- ***What is the risk based capital (RBC) percentages for MAHP members?*** The risk based capital formula is used within the insurance area to measure overall risk related to provider contracts, claims, and enrolled populations. This is a formula recommended by the National Association of Insurance Commissioners, NAIC. Generally a percentage of below 200% results in OFIR regulatory actions. The average for members in MAHP was 441% over the past two years—our not for profit members have higher RBC and for profit members lower.

- ***What is the Standard medical loss ratio for MAHP members?*** Medical Loss Ratio is the percentage of claims for medical services paid each year compared to the premiums earned each year. The members of MAHP do not have a requirement that each line of business must be self sufficient, and therefore the calculation for MLR is for all lines combined. This average for MAHP is about 89% for the past two years. (Medicaid Health Plans (HMOs) are less due to significant administrative requirements and HMOs serving non-Medicare/Medicaid populations have higher MLR. We are obtaining an average for Commercial Health Plans and will make that available for the committee.

- ***What is the average administrative cost for HMOs and Commercial carriers?***
  As referenced above, the filing information and related calculation is based on all products for MAHP members. The formally reported administrative costs average around 7.5% to 8.0%. HMO members with Medicaid are higher and those HMOs serving non-Medicaid are lower admin. While we are obtaining an average for Commercial Health Plans along with the MLR, we can anticipate the administrative costs to be higher due to higher penetration in the individual and small markets.

- ***What is the length of a COBRA benefit?***

Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated. COBRA establishes required periods of coverage for continuation health benefits.

A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and will end at the end of the maximum period. It may end earlier if:

a. Premiums are not paid on a timely basis

b. The employer ceases to maintain any group health plan

c. After the COBRA election, coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

d. After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

Although COBRA specifies certain periods of time that continued health coverage must be offered to qualified beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

- ***Do you have to exhaust the Cobra benefit before apply for conversion?***

COBRA applies to instances where employers or groups have more than 20 employees. Most carriers require you to exhaust COBRA first. Some plans allow participants and beneficiaries to

convert group health coverage to an individual policy. If this option is generally available from the plan, a qualified beneficiary who pays for COBRA coverage must be given the option of converting to an individual policy at the end of the COBRA continuation coverage period. The option must be given to enroll in a conversion health plan within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage. **The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the end of the maximum period of COBRA coverage.**

- ***How long can someone remain in a conversion plan?***

As long as the individual continues to meet the eligibility requirements and pays the premium, they may stay in the conversion plan for an indefinite period of time.

Remaining Issues to be provided to Committee Members:

1. Updated Detail on Medical Loss Ratio
2. Updated Detail on Administrative Cost
3. Information regarding costs of Reinsurance

Link on MAHP website to MAHP PowerPoint presentation on March 17, 2009:
http://www.mahp.org/testimony.html .

cc. House Health Policy Committee Members